that seniors can afford and that our country can afford. Consistent with a letter I signed to the President, I continue to look for ways that we can take this opportunity to reform the current program and ensure we keep the program strong for future beneficiaries.

I understand that the Medicare bill we are debating incorporates disease management as part of the new Medicare Advantage Program, so that private plans offer these services to beneficiaries and that there are several demonstrations to test out a variety of care management techniques in the traditional, fee-for-service program. That is a positive step in the right direction. But I think we need to go further.

I believe strongly that seniors will get better care in a private plan option under this bill, and I encourage them to do so. But I also know there will be seniors that choose to stay in traditional, fee-for-service Medicare. And these will likely be older seniors, the ones that do suffer from multiple chronic conditions and are in the most need for efficient management of their health care. I ask you, can we afford to allow these beneficiaries' health to worsen and to subsequently bear the enormous costs of their care? We cannot. I believe that adding disease management to the traditional-fee-for-service program is a way to reform the system, and to help bring down costs for these seniors. Disease management can reform the system to improve the long-term sustainability of Medicare.

Last week the House Ways and Means and Energy and Commerce Committees both voted in support of legislation that would incorporate disease management into all of Medicare—both private plans and the traditional, fee-for-service programs. I ask that as we move into conference, I hope we can accept the House language that phases in disease management as a permanent part of the Medicare fee-for-service program.

Without a doubt, it is critical to the health of seniors and to the pockets of taxpayers that we implement effective reforms such as disease management in Medicare now—to more rationally and effectively manage care for beneficiaries with chronic conditions, and to ensure the fiscal sustainability of the Medicare Program.

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of multiple sclerosis.

This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS.

Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician. This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with multiple sclerosis.

While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients. It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered.

Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications.

I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

ADEQUACY OF MEDICARE PAYMENTS TO PHYSICIANS

Mr. SPECTER. Mr. President, I have sought recognition today to engage the distinguished chairman of the Finance Committee in a colloquy regarding concerns about the adequacy of Medicare payments to physicians.

Each year, Medicare payments to physicians are adjusted through use of a ''payment update formula'' that is based on the Medicare Economic Index, MEI, and the sustainable growth rate, SGR. This formula has a number of flaws that create inaccurate and inappropriate payment updates that do not reflect the actual costs of providing medical services to the growing number of Medicare patients.

As discussed above, the formula has resulted in numerous payment cuts to Medicare physicians. Earlier this year, Congress passed legislation as part of the fiscal year 2003 omnibus appropriations bill, H.J. Res. 2, that avoided an impending 4.4-percent cut in the Medicare conversion factor. This was accomplished by adding 1 million previously missed Medicare beneficiaries to the mix and recalculating the appropriate formulas. Although this change resulted in a welcomed 1.6-percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services', CMS, preliminary Medicare conversion factor figure predicts a 4.2-percent reduction for 2004. The reason for this latest reduction stems from the fact that the current formula that originally resulted in the need to fix the 2003 conversion factor cut, is flawed. The latest scheduled round of payment cuts will make Pennsylvania's Medicare practice climate untenable.

In its March 2003 report, the Medicare Payment Advisory Commission, MedPac, stated that if ''Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004.'' We owe it to America's physicians to fix the system so that they can continue to provide Medicare beneficiaries with the vital care they need.

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million hit, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005. They simply cannot afford these payment cuts. I know you have worked very hard in preparing a bipartisan Medicare bill that represents a good solid beginning to improving our Nation's health care system. However, I firmly believe this is an issue that Congress must address.

Mr. GRASSLEY. Mr. President, I thank my colleague from Pennsylvania for raising this important issue. He is correct that I have been working with the physician community, as well as the U.S. House of Representatives, to obtain a fuller understanding regarding the adequacy of the current physician formula under Medicare. We have learned that Medicare's current payment formula for physicians is problematic, and I agree that this issue should be addressed. We will continue our discussion, and objectively evaluate proposals that will update the payment formula for physicians.

Mr. SPECTER. I thank the chairman for his willingness to work with me on this issue as the Prescription Drug and Medicare Improvement Act moves forward.

The PRESIDING OFFICER. The Senator from Missouri.

MORNING BUSINESS

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

SALUTE TO THE 129TH MOBILE PUBLIC AFFAIRS DETACHMENT

Mr. DASCHLE. Mr. President, on July 12, the 5th U.S. Army will demobilize the 129th Mobile Public Affairs Detachment of the South Dakota National Guard. This unit, headquartered in Rapid City, was among more than 20 Guard and Reserve units from my State called to active duty in support